Client-Level Data Collection Guide

Healthy Aging Alberta Programmatic Initiatives

August 2023

Healthy Aging Alberta

PolicyWise for Children & Families

Welcome

Hello!

Healthy Aging Alberta (HAA) and PolicyWise for Families & Children (PolicyWise) thank you for your effort to align your data collection activities with the common approach that it is outlined in this Guide. We have collaborated together, and with many community partners to arrive at this data collection approach. With the Guide in hand, and with some help from HAA and PolicyWise along the way, we hope aligning your organization's data collection activities is as straight forward as possible. If you would like to reach out for support, please connect with the appropriate HAA Project Manager for your program (Appendix 1).

Healthy Aging Alberta is a rich network of community-based senior serving organizations and allies across our province united by a shared vision: to make Alberta one of the best places in the world to grow older. HAA was established to connect community-based senior serving (CBSS) organizations with one another and with aging networks, as well as with larger allied systems such as health, housing, and the disability sectors. Unlike the health or housing sectors, CBSS organizations were lacking a defined sector with a coordinated vision and approach. Coordinating CBSS efforts is critical in meeting the needs of the growing demographic of older Albertans and enabling every senior to age in the way they want.

PolicyWise for Children & Families is an Alberta-based not-for-profit organization that believes everyone should have access to the most accurate information when making decisions. PolicyWise exists to inform, identify, and promote effective social policy and practice to improve the well-being of children, youth, families, and communities. PolicyWise collaborates and partners with all levels of government, academia, and other not-for-profit organizations to develop effective, evidence-informed policies, programs, and services. Projects are guided by the vision that all members of community thrive in respectful, safe, and supportive environments shaped by wise decisions.

Summary

- Collecting data in a consistent way helps the CBSS sector tell a compelling story.
- We are asking you to adopt a short set of Core Questions into your client assessment activities.
- We ask that you adopt these questions and the response options exactly as they are worded.
- There are four recommended steps you might follow in adopting the core questions.
- You can receive one-on-one support at any time from the appropriate HAA Project Manager.

Introduction

Guide Purpose

This guide aims to support organizations in the measurement of outcomes achieved with older adult clients receiving community-based services across Alberta. Overall, the goal in creating this guide has been to make the data collection process as easy and efficient as possible for both clients and staff. By following this guide and collecting data in a consistent way, the sector can use the information to tell a compelling story about the impact of the community-based senior serving sector.

Guide Development

This guide has been developed through a thoughtful process. Considerations have included: alignment with the HAA's Healthy Aging Framework; alignment with what information the community-based organizations are already collecting; reflection on evaluation learnings from previous and ongoing HAA programmatic initiatives; and further engagement with organizations funded through the programmatic initiatives. One of the most important considerations has been balancing the needs for data collection with the challenges providers face in collecting this information. It is important for the data collection to not put undue stress or pressure on the provider – client relationship.

Intended Use and Users

This guide can be used by program staff engaged in providing community-based services and programs in the CBSS sector who are interested in measuring the impact their program is having on the clients they serve. The approach described can be used to inform adaptations to the questions you already ask, the tools you use to collect information, and the frequency in which you use data collection tools with your clients. The questions should be embedded in the program's current client assessment processes. The questions can be used to support the provider - client relationship by helping to enhance the provider's understanding of client's needs, the progress they are making on strengthening their determinants of health, and what the next steps in their care support might be.

HAA Programmatic Initiatives

Over the past few years HAA has secured funding from multiple sources to address priority issues identified by the CBSS sector. HAA has used the funding to create programmatic initiatives that provide grants to CBSS organizations across Alberta to enhance their capacity to offer new or expanded services and programs. Initiatives have included the Aging in Community project, the Community and Home Supports Provincial Model, and the Social Prescribing project. All of HAA's work is guided by the Healthy Aging Framework in alignment with the Government of Alberta's Recovery-Oriented Systems of Care.

The Healthy Aging Framework

The Healthy Aging Framework provides a shared language and way of understanding the work that CBSS organizations do. It is a tool for organizing the programs and services of seniors serving organizations to support an integrated, community-based, and person-centred approach to aging in Alberta. Two components of the Health Aging Framework have been integrated into the Evaluation Framework to ensure and demonstrate alignment between what community-based organizations do and how their impact is measured. These two components are The Six Determinants of Health Aging and the Impact Areas which are defined in the section below and listed in Appendix 2.

Evaluation Framework – Client Data Collection

As a practical tool, the Evaluation Framework assists programs in understanding which questions you should ask your clients, the type of assessment tool you should include the question in, and the frequency in which you should ask the questions to your clients. It is the frequency, or the repeated asking of the same questions over time that allow for the measuring of program impact on the client during their journey with your program. While each program may have a specific evaluation framework, a general evaluation framework which forms the foundation for evaluation for all programs can be found in Appendix 3. The Evaluation Framework includes the components described below in Table 1.

Table 1. Evaluation Framework Components

Component	Description
Evaluation Questions	The questions that help focus the evaluation related to the priorities and needs of its stakeholders.
Determinants of Healthy Aging	Identified in the Health Aging Framework – Six inter-related categories that identify the things that determine a person's ability to remain healthy as they age.
Impact Areas	Identified in the Health Aging Framework – The things the seniors serving sector think will change overall as a result of the work they do.
Indicators	The types of information the program can collect to understand if they are achieving their outcomes.
Measures	The question that can be asked, or the data that can be collected, to assess progress on the indicators.
Data Source	The tool or activity that will be used to collect the measures.
Audience	Who the tool or activity will be implemented with.
Frequency	How often the tool or activity will be implemented.

Gathering Evidence: Data Collection

Overview

This section presents the questions you should ask, how frequently you should ask them, where to store the collected data, and the steps you might take to integrate the data collection approach into your current client assessment process.

It is important to note that the Core Questions should be embedded in your program's current client assessment processes. This is not meant to be a stand-alone evaluation activity. In addition to helping your program and the sector understand our impact, the questions can be used to support the provider - client relationship by helping to enhance the provider's understanding of client needs, the progress client are making on strengthening their determinants of health, and what the next steps in their care support might be.

Questions to Ask

There are three types of questions presented in this Guide. These types are: Demographics; Outcome Measures; and Program Improvement. The question types and the recommended frequency of collection are summarized below in Table 2. These types are further divided into two categories:

- **Core Questions**: These questions should be adopted, and the wording of the questions and the response options should be adopted exactly as they are written in this guide. The Core Questions can be found in Appendix 4.
- **Optional Questions**: These questions should be considered, and the wording of the questions and response options can be altered to fit the needs and preferences of your program. The Optional Questions can be found in Appendix 5.

Table 2. Question Types and Frequency of Collection

Question Type	Description	Frequency
Demographics	To understand who you are serving and if there are differences in the impact your program has on people in different circumstances	Intake or Referral
Outcome Measures	To understand your clients' needs, progress, and next steps	Intake 6-months Exit/Closing
Program Improvement	To understand why your clients are exiting your program and to solicit client feedback on how you might improve your program	Exit or Closing

Demographics questions should be asked at Intake or Referral, ***Outcome Measures*** questions should be collected at all three time points, and the ***Program Improvement*** questions should be asked at Exit. When a client leaves the program before an exit conversation can take place a question is included to understand why the client left the program before their care plan was complete (i.e., file "Closing"). Outcome Measures questions should be added to Intake and Referral, 6-Month Assessment, and

Program Exit/Closing tools. In this way, this information is collected at three time points in the client's journey which is the minimum number of time points required to be confident in determining a trend in a client's progress. The suggested time points are described below in Table 3.

Table 3. Time Period Descriptions

Time Period	Description
Intake or Referral	This information can be collected through referral forms completed by the health care providers, or included in tools used to collect program intake information. This information is collected during the beginning of the client's journey in your program.
6-Months	This information can be collected through tools used for assessment and care planning, and is collected while the client is mid-journey.
Exit or Closing*	This information can be collected through tools used to support reflection with the client at the end of their journey with your program. "Exit" is used to reflect when a provider is able have a final meeting with the client and "Closing" is used to reflect when the provider is unable have a final meeting with the client due to any circumstance.

*Note: If a client were to end their journey with your program within three months after their 6-Month Assessment, there is no need to repeat the Outcomes Measures questions at Exit or Closing. However, the program improvement questions should still be asked. If the client's journey ends longer than three months after their 6-Month Assessment, the entire Exit or Closing Assessment should be completed.

Data Management

Services and programs should integrate the information collected into their existing data management system. The data will be collected and entered into data systems at the individual, or client level. This means that the data collected will be stored in each client's electronic program file. Collecting data at the individual level allows for a stronger analysis of the client journey. It also helps learn about how CBSS services impact people who come from different circumstances. For example, client-level data allow for comparing the impact a program has on clients who may be at-risk of homelessness versus clients who have stable housing. This type of learning is important for program improvement and for building a provincial approach for social prescribing supports.

Organizations will be asked to submit their anonymized, client-level data for provincial analysis and reporting. The data management systems and approach to facilitate this is still in development.

The Steps You Might Take

The Four Steps

Suggested here are four steps to aligning your current data collection approach with the approach described in this guide. Although there are only four steps, this activity can be quite challenging for programs to complete. There are many decisions to make, and it is best to work through each step one at a time.

1. Review your existing data collection approach and determine if it aligns with collecting data at all three recommended time points: Intake or Referral; 6-Month Assessment; and Exit or Closing.
    - Consider aligning your data collection approach to collect data at these three time points.
2. Review your existing Intake/Referral, Assessment, and Exit/Closing tools to determine if there is any overlap between the questions you already ask, and the core questions in this guide.
    - Consider removing any overlapping questions from your existing tools and adding the core questions.
    - Consider adding the core questions to the appropriate tools.
    - Consider adding any optional questions that are of interest to your program.
3. Integrate the questions into your existing client information management system.
4. Train and support your staff through the change.
    - Consider communicating with staff about the importance of the changes for demonstrating the value of your services to your clients.
    - Consider any training that might be helpful for staff to feel more comfortable in asking the questions and responding to the answers provided by their clients. This includes understanding how answers to the questions can provide information that is helpful for understanding client needs and the progress clients are making through their care plan.

One-on-One Support

If you would like one-on-one support at any point in this process, please reach out to the appropriate HAA Project Manager for your program. If you don't know them already, you can find a list of the HAA Project Managers in Appendix 1.

Appendix 1: HAA Programmatic Initiative Project Managers

Beth Mansell
Social Prescribing
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Community & Home Supports
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Appendix 2: Health Aging Framework

The Healthy Aging Framework includes six Determinants of Health Aging, and twelve Impact Statements.

Determinant of Health Aging	Impact Statements
Personal Wellbeing	Increased ability to cope with challenges and life transitions
	Increased access to information, programs, services, and supports to manage the activities of daily living
	Increased capacity to live independently by enhancing physical wellness
	Increased sense of meaning, purpose, and connection to the larger world
Physical and Mental Health	Increased capacity to live independently by enhancing mental wellness
	Increased capacity to live independently by enhancing physical wellness
	Increased engagement in creative pursuits and intellectually stimulating activities to keep the mind alert and interested
Physical Environment	Increased ability to reside in the place that is appropriate for one's circumstances
Safety and Security	Increased capacity to maintain personal safety, security, and the integrity of personal decisions as one ages, and personal circumstances change
Social Environment and Engagement	Increased inclusion and access for Indigenous, marginalized, racialized, and/or low-resources older adults
	Increased sense of meaning, purpose, and connection to the larger world
	Increased sense of purpose, belonging, and ability to cope with change and life transition
	Reduced risk of isolation and loneliness
Social Support	Increased ability to balance personal wellbeing with the role of a care partner
	Increased access to information, programs, services, and supports to manage activities of daily living

Appendix 3: HAA Programmatic Initiatives Evaluation Framework – Client Data Collection

	Evaluation Questions	HAF Determinants of Healthy Aging	HAF Impact Areas	Indicators	Core Measure(s)	Data Source	Audience	Frequency
Older Adults	To what extent, and in what ways, are regional project making progress towards achieving anticipated outcomes for older adults?	Personal Wellbeing	Increased access to information, programs, services, and supports to manage activities of daily living.	Older adults report new or improved knowledge and skills	In general, I am aware of the services and supports available to me. I am able to access the services and supports I need.	Client Assessment Survey/Form	Clients	Intake 6 Months Closing
		Physical and Mental Health	Increased capacity to live independently by enhancing mental wellness.	Older adults report change or stabilization in scores on self-reported mental wellbeing.	How often in the last few months have you been bothered by low feelings, stress, or sadness?	Client Assessment Survey/Form	Clients	Intake 6 Months Closing
		Physical and Mental Health	Increased capacity to live independently by enhancing physical wellness.	Older adults report change or stabilization in scores on self-reported physical wellbeing.	In general, how would you rate your physical health?	Client Assessment Survey/Form	Clients	Intake 6 Months Closing
		Social Environment and Engagement	Reduced risk of isolation and loneliness.	Older adults report increased change or stabilization in how content they are with their connections.	How content are you with your connections?	Client Assessment Survey/Form	Clients	Intake 6 Months Closing
		Social Environment and Engagement	Increased sense of meaning, purpose, and connection to the larger world.	Older adults report stable or improving quality of life.	How would you rate your quality of life?	Client Assessment Survey/Form	Clients	Intake 6 Months Closing
		Safety and Security	Increased capacity to maintain personal safety, security, and the integrity of personal decisions as one ages, and personal circumstances change.	Older adults report they are in control of the decisions that impact their lives as they age.	I feel I have control over my life.	Client Assessment Survey/Form	Clients	Intake 6 Months Closing
Health System	To what extent, and in what ways, is the regional project making progress towards achieving anticipated outcomes for the health sector?	N/A	Outcome: There is less reliance on formal health systems	Older adults report stabilization or reduction in emergency room visits. Older adults report stabilized or reduction in time spent in hospital.	Thinking about the past 6 months, have you been hospitalized? (how many times, total days) Thinking about the past 6 months, have you needed to go to the emergency room? (how many times)	Client Assessment Survey/Form	Clients	Intake 6 Months Closing

Appendix 4: Core Questions

Ask these questions at time or referral or intake.

Demographics

1. **Reason for accessing services: _____**
2. **Referral Source:**
    - ☐ Hospital
    - ☐ Primary Care Network
    - ☐ Family Doctor
    - ☐ Home Care
    - ☐ Other
3. **Age Category:**
    - ☐ 50-54
    - ☐ 55-64
    - ☐ 65-70
    - ☐ 71-74
    - ☐ 75-80
    - ☐ 80+
4. **Gender:**
    - ☐ Male
    - ☐ Female
    - ☐ Gender Diverse (LGBTQ2s+)
5. **Do you identify/consider yourself:**
    - ☐ Black
    - ☐ East Asian
    - ☐ Indigenous
    - ☐ Latin American
    - ☐ Multiple ethnicities
    - ☐ Southeast Asian
    - ☐ South Asian
    - ☐ West Asian
    - ☐ White
    - ☐ Another ethnicity or ethnicities not listed, please specify: _____
    - ☐ Prefer not to answer
6. **What is your marital status**?
    - ☐ Married/Common-law
    - ☐ Separated
    - ☐ Divorced
    - ☐ Widowed
    - ☐ Involuntary Separation (i.e., no longer able to live with partner)
    - ☐ Single, never married
7. **Who do you live with?**
    - ☐ Live alone

- ☐ Live with roommates
- ☐ Live with spouse/partner
- ☐ Live with dependents
- ☐ Live with extended family
- ☐ Currently experiencing homelessness
- ☐ Another living arrangement not listed, please specify: _____
- ☐ Prefer not to answer

8. **Do you have access to reliable and affordable transportation?**
   - ☐ Yes
   - ☐ No
9. **Do you have a consistent primary healthcare provider?**
   - ☐ Yes
   - ☐ No
10. **What is your best estimate of your total personal income, before taxes and deductions, from all sources during the year ending December 31, 2022?**
    - ☐ No income
    - ☐ Under $1,000
    - ☐ $1,001 - $10,000
    - ☐ $10,001 - $30,000
    - ☐ $30,001 - $50,000
    - ☐ $50,000+

Outcome Measures

Ask these questions at the time of referral or intake, six months after intake, and at exit or closing.

Isolation and Loneliness

I am content with my connections (e.g., family, friends, cultural, spiritual)?

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Agree
- ☐ Strongly agree
- ☐ Provider: It is not appropriate for me to ask my client this question at this time.

Physical & Mental Wellbeing, Quality of Life

In general, how would you rate your physical health? This refers to things like physical fitness, and freedom for physical symptoms of illness such as pain and discomfort.

- ☐ Excellent
- ☐ Good
- ☐ Fair
- ☐ Poor
- ☐ Provider: It is not appropriate for me to ask my client this question at this time.

How often in the last few months have you been bothered by low feelings, stress, or sadness?

- ☐ Never
- ☐ Rarely

- ☐ Sometimes
- ☐ Often
- ☐ Provider: It is not appropriate for me to ask my client this question at this time.

How would you rate your overall quality of life? This refers to things like the ability to enjoy life, get along with family members, and satisfaction with living conditions.

- ☐ Excellent
- ☐ Good
- ☐ Fair
- ☐ Poor
- ☐ Provider: It is not appropriate for me to ask my client this question at this time.

Capacity to Maintain Personal Safety, Security, & Integrity

I feel I have control over my life. This refers to control in things like decision-making, time management, and planning my days.

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Agree
- ☐ Strongly agree
- ☐ Provider: Not applicable - this client has a designated person to make decisions on their behalf.
- ☐ Provider: It is not appropriate for me to ask my client this question at this time.

Access to Services and Supports

In general, I am aware of the services and supports available to me.

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Agree
- ☐ Strongly agree
- ☐ Provider: It is not appropriate for me to ask my client this question at this time.

I am able to access the services and supports I need.

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Agree
- ☐ Strongly agree
- ☐ Provider: It is not appropriate for me to ask my client this question at this time.

Hospital Use

I'd like to get a sense of how frequently you need to go to the emergency room or hospital.

1. Thinking about the past six months, have you been hospitalized?
   - ☐ Yes
   - ☐ No

   If yes, how many times ___.

   If yes, how many total days ___.

2. Thinking about the past six months, have you needed to go to the emergency room?
   - ☐ Yes
   - ☐ No

   If yes, how many times ___.

Program Improvement

Ask these questions at the time of the client exiting the program, or when the provider is closing the client's file.

Access to Services and Supports

1. How have your knowledge and skills grown through participation in this program?
2. Since you've been involved with our program, which supports and services that you are receiving are most useful to you? And why?
3. Are there any other supports and services you are not receiving that would be helpful?

Unable to Complete an Exit or Closing Survey

Provider: If known, please note the reason the client is no longer receiving services and has not completed a closing form:

- Client has passed away
- Client has moved out of service area
- Client has moved to assisted living/care facility
- Client is unreachable/no longer engaged
- Other _____

Appendix 5: Optional Questions

Outcome Measures

Consider asking these questions at the time of referral or intake, six months after intake, and at exit or closing.

Isolation and Loneliness

I am content with my friendships and relationships.

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Agree
- ☐ Strongly agree
- ☐ Provider: It is not appropriate for me to ask my client this question at this time.

I am content with my spiritual connections.

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Agree
- ☐ Strongly agree
- ☐ Provider: Not applicable – if the client does not identify as being spiritual
- ☐ Provider: It is not appropriate for me to ask my client this question at this time.

I am content with my cultural connections.

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Agree
- ☐ Strongly agree
- ☐ Provider: It is not appropriate for me to ask my client this question at this time.

Physical & Mental Wellbeing, Quality of Life

Thinking about your usual daily activities, including things like hygiene, employment, housework, and family or leisure activities, do you have any problem performing them?

- ☐ I have no problems performing my usual activities
- ☐ I have slight problems performing my usual activities
- ☐ I have moderate problems performing my usual activities
- ☐ I have severe problems performing my usual activities
- ☐ I am unable to perform my usual activities
- ☐ Provider: It is not appropriate for me to ask my client this question at this time.

How satisfied are you with the way you use your time?

- ☐ Very unsatisfied
- ☐ Somewhat unsatisfied
- ☐ Somewhat satisfied
- ☐ Very satisfied
- ☐ Provider: It is not appropriate for me to ask my client this question at this time.

How often do you participate in social activities such as hobbies you enjoy, visiting with friends, and other recreational activities?

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Often
- ☐ Provider: It is not appropriate for me to ask my client this question at this time.

Capacity to Maintain Personal Safety, Security, & Integrity

I feel confident, or comfortable, living at home right now.

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Agree
- ☐ Strongly agree
- ☐ Provider: It is not appropriate for me to ask my client this question at this time.

Access to Services and Supports

I have enough people I feel comfortable asking for help at any time.

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Agree
- ☐ Strongly agree
- ☐ Provider: It is not appropriate for me to ask my client this question at this time.